PROVIDER SURVEY QUESTIONNAIRE

State Form 53183(12-06)
INDIANA STATE DEPARTMENT OF HEALTH
LONG TERM CARE

The Indiana State Department of Health, Long Term Care Division (LTC) recently performed a survey in your facility. Please evaluate the LTC survey performance by taking a few minutes to complete and return this questionnaire.

Your completion and return of this questionnaire will help the Long Term Care Division continue to improve the survey process, and thereby serve you and others more effectively.

The purpose of this questionnaire is to improve the quality of the survey process through your responses to the questions contained herein. The information in this questionnaire will have no negative impact on the survey or subsequent survey activities in your facility.

Thank You,

Sue Hornstein, Director
Long Term Care Division

PLEASE RETURN THIS FORM TO: SUE HORNSTEIN, DIRECTOR OF LONG TERM CARE, IN THE PROVIDED ENVELOPE WITHIN 2 DAYS OF SURVEY EXIT

Using the scale below, please check the number that applies.
5: Strongly Agree **4:** Agree **3:** Neutral **2:** Disagree **1:** Strongly Disagree **NA:** Not Applicable

QUESTION:	5	4	3	2	1	NA	COMMENT:
1. Survey process was clearly explained.							
2. Surveyor conducted the survey in such a manner to minimize disruption of the facility's routine.							
3. Client/patient/resident reaction to the survey was positive.							
4. Communication with surveyor(s) was on-going during survey.							
5. Provider/facility had opportunity to discuss daily survey concerns with the surveyor(s).							
6. Received knowledgeable response from surveyor(s) if provider/facility requested clarification during survey process.							

Using the scale below, please check the number that applies.
5: Strongly Agree **4:** Agree **3:** Neutral **2:** Disagree **1:** Strongly Disagree **NA:** Not Applicable

QUESTION:	5	4	3	2	1	NA	COMMENT:
7. The survey was conducted in a professional and courteous manner – surveyor(s) interacted with staff in a respectful manner.							
8. Surveyor(s) interacted respectfully with facility residents.							
9. Surveyor(s) maintained confidentiality and privacy of residents/clients during conversations and survey observations.							
10. Adequate information was provided during the exit conference to allow facility staff to understand any areas of non-compliance. Surveyor(s) were receptive to materials provided by the facility and appeared to conduct a review of those materials in consideration of voiced concerns.							

Additional comments or information about the onsite survey process:

Please recommend one change that would improve the survey experience:

Type of on-site survey conducted *(please identify all that apply)*:

☐ Medicare/Medicaid Certification ☐ State Licensure Only ☐ Follow-up Survey

☐ Complaint Investigation ☐ LSC/Physical Environment ☐ Other

Facility Name: _____

Facility Address: _____
(number and street, city, state, and ZIP code)

Date of Survey: _____
(month, day, year)